CALVARY HEALTH CARE BETHLEHEM REFERRAL FOR ADMISSION Phone: 9834 9423 Fax: 9834 9494	Calvary Health Care Bethlehem Email to: BET-Access&Intake@calvarycare.org.au

Referral To - (please choose one)	Referral Reason
☐ Inpatient ☐ Community Palliative Care Services ☐ State-wide Progressive Neurological Diseases Services (SPNDS) Do not use this form for NDIS….for an **NDIS Service Request Form** click > **here**	☐ Terminal Care ☐ Assessment ☐ Symptom Management ☐ Maintenance

Date of Referral:

Please note the referral cannot be processed unless * items are complete

* Referrer Details	Patient Details
Organisation: nbmm	* CONSENT ☐
Name: gng	* Title:
Designation: fnn	* Surname
Phone: nfn	*Given Names(s):
Mobile:	*Address:
Fax:	*Home Phone:
Email:	*Mobile:
Address:	*Email:
* Name of Referring Doctor as per AHPRA registration if different from Above:	Preferred mode of Contact: ☐ home phone ☐ mobile ☐ email
	* Date of Birth:
* Referring Doctor Provider Number:	Gender: ☐ Male ☐ Female ☐ Other
	* Country of Birth:
* Primary Support Person / Carer (ie., NOK / MTDM)	Preferred Language:
Surname:	Interpreter Needed: ☐ Yes ☐ No
First Name:	☐ Aboriginal ☐ Torres Strait Islander
Address:	Religion:
Phone/ Mobile	Medicare | Insurance
Email	*Medicare No:
Relationship to Patient	Medicare Reference No:
Lives with Patient ☐ Yes ☐ No	Private Health Fund:
Preferred Contact Person: (incl. name and contact number if different to primary support person)	Health Fund No:
	DVA:

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Patient Social Situation	**Specialist Name**
☐ Lives Alone ☐ Lives with Carer	Name:
☐ Residential Care ☐ Low Level ☐ High Level	Clinic:
***General Practitioner**	Address:
Name:	Phone:
Clinic:	Fax:
Address:	Other Service Providers
Phone:	Details:
Fax:	
Allied Health assessments and Equipment	
☐ Yes ☐ No	

Does the patient have an existing advance care plan / advance care directive or goals of care document?

Yes ☐ If Yes, please attach a copy to this document No ☐

Reason for Referral | Current Issues

Please include any information which may be useful as background information to assist with the referral

Patient and family expectations:

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Diagnosis/ Past medical History:
Critical Handover | Information:
Allergies:
Behavioural or cognitive concerns:
*** PLEASE ATTACH THE FOLLOWING RELEVANT INFORMATION TO ALLOW THIS REFERRAL TO PROGRESS (tick items attached)**
☐ Discharge Summary ☐ Pathology & Radiology Report ☐ Equipment Provided ☐ Other Relevant Clinical Information ☐ Anticipatory Medication Orders ☐ Services Arranged or in Place ☐ Lung Function Tests ☐ EMG /NCS ☐ MRI / CT
Signed:
Name:
Designation:
Date: